Tarzana Outpatient Surgical Institute
5620 Wilbur Ave. Suite 305 Tarzana, CA 91356
818-578-5125

CONDITIONS OF ADMISSION

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES:** The undersigned consents to the procedures which may be performed on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, anesthesia or outpatient services rendered to the patient under the general and special instructions of the patient's physician or surgeon. The undersigned also consents to the admission to a hospital post-operatively should the treating health care provider deem this necessary.

2. **NURSING CARE:** The surgery center provides only general duty nursing care unless, upon orders of the patient's attending physician or surgeon, the patient is provided with more intensive care. If the patient's condition is such as to need the services of a special duty nurse, it is agreed that the patient or his/her representative must arrange such. The surgery center shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

3. **TISSUE DISPOSAL**: I hereby authorize the pathologist to use his/her discretion in the disposal of any severed tissue member or organ removed from me during the operation or procedure described above.

4. **CONSENT TO BLOOD AND/OR BLOOD PRODUCT TRANSFUSIONS:** I understand that should I need blood products, I will be transferred to an acute care hospital for the delivery of such.

5. **LEGAL RELATIONSHIP BETWEEN SURGERY CENTER AND PHYSICIAN/ SURGEON:** All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist and the like, are independent contractors with the patient and are not employees or agents of the surgery center. The patient is under care and supervision on his/her attending physician or surgeon, and is the responsibility of the surgery center and its nursing staff to carry out the instructions of such physician or surgeon. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures or outpatient services rendered to the patient under the general and special instructions of the physician or surgeon. Any questions concerning the nature or results of any examination or treatment should be directed to the patient's attending physician or surgeon and not the surgery center employees.

6. **CONSENT TO TRANSFER:** I understand that the surgical and/or diagnostic procedures to be performed on me at this Center will be done on an outpatient basis and the facility does not provide for 24-hour patient care. If my attending physician or any other duly qualified physician in his/her absence, shall find it necessary or advisable to transfer me from the facility to a hospital or other health care facility. I consent and authorize the employees of the facility to arrange for and affect the transfer.

I further consent to the release of my information pertaining to my medical care should admission to an acute care facility become necessary during or within 72 hours following my admission to the surgical center, I authorize my medical records from the admitting acute care facility to be released to the Center.

7. **RELEASE OF INFORMATION:** Upon inquiry and to the extent allowed by law, the surgery center may make available to the public certain basic information about the patient, including name, address, age, sex, general description of the reason for treatment (whether an injury, burn, poisoning, or other condition), general nature of the injury, burn, poisoning, or other condition and general condition. If the patient's representative does not want such information to be released, he/she must make a written request for said information to be withheld. The patient or his/her representative may obtain a separate form from the surgery center for this purpose.

8. **PERSONAL VALUABLE:** It is agreed an understood that the surgery center shall not be responsible for any personal property, including but not limited to money, jewelry, documents, or other articles of unusual value. It is agreed and understood that if the patient elects to leave personal valuables in the patient lockers during surgery, the surgery center is not liable for loss or damage to said property.

9. **FINANCIAL AGREEMENT:** The undersigned agrees, whether he/ she signs as agent or as patient, that is consideration of the services rendered to the patient, he/she is hereby individually obligates himself/herself to pay the account of the surgery center in accordance with the regular rates and terms of the surgery center. Should the account be referred to any attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest as the highest rate allowed by law. The undersigned assumes all financial responsibility for any post-operative hospitalization. The undersigned further acknowledges that the surgeon may or may not have financial interest in the organization. Further information can be furnished upon request.

10. **INSURANCE PAYMENT ACKNOWLEDGEMENT:** I further authorize the facility to endorse and deposit the checks received on my account when made out to me for the payment of the services rendered to me at Brand Tarzana Surgical Institute. I further authorize the bank to deposit the check for the amount stated by the insurance company into Brand Tarzana Surgical Institute's account with no further delay. I hereby instruct and direct my insurance company to pay by check made out and mailed to:

Brand Tarzana Surgical Institute
5620 Wilbur Ave. Suite #305
Tarzana, CA 91356

OR

If my current policy prohibits direct payment to the facility, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Brand Tarzana Surgical Institute
5620 Wilbur Ave. Suite #305
Tarzana, CA 91356

Patient's Initials_____(2CA)

Tarzana Outpatient Surgical Institute
5620 Wilbur Ave. Suite 305 Tarzana, CA 91356
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For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered. This is a direct assignment of my right and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a current manner, any balance of said service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. Brand Tarzana is authorized to file an appeal and seek claim status for the services rendered.

I authorize the facility to initiate a complaint to the insurance commissioner for any reason on my behalf.

10. **HEALTH CARE SERVICES PLAN OBLIGATION:** The surgery center maintains a list of health care service plans which it has contracted. A list of such plans is available upon request from the financial office. The surgery center has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees whether he/she signs as agent or patient, that he/she is individually obligated to pay the full charge for all the services rendered to the patient by the surgery center, if he/she or the patient belongs to a plan which does not appear on the above mentioned list.

11. **CONSENT TO PHOTOGRAPHS:** I authorize my physician and or Brand Tarzana Surgical Institute, or any of their designated assistants to take photographs of me at any point in my medical treatment. If my physician feels the photographs are beneficial to medical research or education, such photographs and related information may be published and republished in professional journals or medical books, or used for other purposes in the interest of medical education for allied medical personnel and lay persons. Identifying features may be visible but I shall not be identified by name in any publication. I hereby authorize Brand Tarzana Surgical Institute to use the photographs for advertisement purpose. These photographs maybe modified or retouched in any way that my physician considers desirable.

The undersigned certifies that he/she has read the foregoing, received a copy of thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this document and accept and agree to its terms. Furthermore, the undersigned certifies that he/she was given a copy of patient's rights and responsibilities, advance directives notice, and financial agreement in advance (at least 24 hours prior to surgery date) for review and accepts it.

_____	_____	_____
Signature of Patient/Parent/Guardian	Date	Time

_____	_____
Name of Patient/ Parent/ Guardian	If other than patient, indicate relationship

_____	_____	_____
Witness	Date	Time

_____	_____	_____
Financially Responsible Party	Date	Time

Financial Responsibility Agreement by person other than patient or the patient's legal representative; I Agree to accept all financial responsibility for services rendered to the patient and to accept the terms of Financial Agreement, Assignment of Insurance Benefits, and Health Care Services Plan Obligation provisions enumerated above.